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1 UNITED STATES DISTRICT COURT
2 SOUTHERN DISTRICT OF OHIO
3 WESTERN DIVISION
4 - - - - -
5 ERIC L. JEFFRIES, :
6 Plaintiff, :
7 vs. : Case No. C-1-02-351
8 CENTRE LIFE INSURANCE : (Volume I)
9 COMPANY, et al., :
10 Defendants. :
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12 Deposition of MICHAEL MCCLELLAN, MD, a
13 witness herein, called by the defendants for
14 cross-examination, pursuant to the Federal Rules of
15 Civil Procedure, taken before me, Connie Dupps, a
16 Registered Professional Reporter and Notary Public
17 in and for the State of Ohio, at the offices of Hyde
18 Park Internists, 2727 Madison Road, Cincinnati,
19 Ohio, on Tuesday, October 14, 2003, at 3:00 PM.

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24

1 A. Okay.

2 Q. All right. Doctor, last night your office
3 was kind enough to give me a copy of your records in
4 the case of Eric Jeffries. Do you recall Mr.
5 Jeffries as a patient?

6 A. I do.

7 Q. Can you tell me from your records, which I
8 assume you have with you, when the first time you
9 saw him would have been?

10 A. Actually I first saw Eric 5 years ago to
11 the day today, October 14, 1998.

12 Q. What was the occasion of that visit, what
13 brought him to you?

14 A. Mr. Jeffries had been under the primary
15 care of Dr. Donald Nunlist-Young, and at that time
16 was also under the care of several other specialists
17 being evaluated for an, as yet undefined, illness,
18 and he felt that he wanted another primary care
19 opinion from a generalist. He had seen a few
20 different specialists, but wanted someone other than
21 Dr. Nunlist-Young to examine him and give another
22 opinion on his illness.

23 Q. Okay. When you first saw him I assume you
24 made a record of the history that he gave you?

1 A. The list of potential diagnoses was very
2 broad and it included everything from infections;
3 those would be, for example, mononucleosis, Ebstein
4 bar virus infection, cytomegalovirus, herpes virus
5 infections, as well as infections caused by, what we
6 call, vectors, mosquito bite born, arthropod born
7 infections, for example, Lyme disease.

8 They include many rheumatologic diseases,
9 autoimmune disorders, lupus, rheumatoid arthritis,
10 Behcet's disease, B E H C E T apostrophe S, as well
11 as fibromyalgia, a nonautoimmune rheumatologic
12 disorder, endocrinologic disorders, thyroid disease.

13 And there are other potential causes that
14 we eventually looked into that include some very
15 rare disorders, but I think at the time I originally
16 saw him those were the initial primary
17 considerations that had been looked at at that
18 point.

19 Q. Over the course of time were you able to
20 narrow the list?

21 A. We were able to exclude many of the
22 disorders that we considered. We also went on to
23 look into various gastrointestinal problems because
24 he had abdominal pains as part of his symptom

1 complex, so we considered inflammatory bowel
2 diseases, other infectious and noninfectious
3 problems of the bowel, some very strange disorders,
4 porphyrias, Whipple's disease, paroxysmal nocturnal
5 hemoglobinuria, some diseases that I've only read
6 about in textbooks and in 15 years in practice never
7 seen a case of.

8 So we really did an extensive evaluation
9 over the course of the next couple of years that I
10 was caring for Eric to try to exclude every possible
11 organic etiology that we could for his symptoms.

12 Q. Are you still caring for Mr. Jeffries at
13 this time?

14 A. Yes.

15 Q. Did you do a physical examination on your
16 first visit?

17 A. Yes.

18 Q. Was it essentially a normal exam?

19 A. Other than some mild tenderness in his
20 right upper quadrant that I could elicit, everything
21 else was normal.

22 Q. Were you advised of, in his medical
23 history, that he had bouts of difficulties with his
24 right upper quadrant or pain in his right upper

1 quadrant that predated the hepatitis injections?

2 A. I don't believe that I was aware of that
3 as a predating condition.

4 Q. Are you aware of it today that it was a
5 predating condition?

6 A. I have notes from my initial evaluation
7 that he has -- that he had an evaluation of his
8 right upper quadrant pain, including an ultrasound
9 of his gallbladder and liver, but I was not then,
10 and I don't believe I'm aware now, that that was a
11 condition that existed before his immunizations.

12 Q. Okay. So you have seen no records from
13 him going back into the '93, '94, '95, '96 era?

14 A. No. My review of his records were based
15 on the time of his illness since he became acutely
16 symptomatic.

17 Q. Coming forward?

18 A. (Nodding head.)

19 Q. It would be of interest to you, however,
20 as a diagnostician to know whether or not he had
21 been treated for right upper quadrant pain or
22 epigastric pain prior to his injection, correct?

23 A. Correct.

24 Q. That would be significant history given

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1 it's an ongoing symptom?

2 MR. ROBERTS: Objection.

3 A. It would be important to know the dating
4 of that symptom.

5 Q. Were you advised that prior to -- we use
6 the injection as the event date since that is his
7 contention, correct, that this all -- all of the --
8 all of the problems that he's having stemmed from
9 this injection, correct?

10 MR. ROBERTS: Objection.

11 A. Right.

12 Q. So if we use that as the date of the
13 event, were you advised that prior to the event he
14 had been diagnosed and treated for the herpes virus?

15 MR. ROBERTS: Objection. Go ahead.

16 A. Can you say that again, please.

17 Q. Yes. Prior to the event date were you
18 made aware that he had been treated for the herpes
19 virus or for a herpes infection?

20 A. So your question is was I aware --

21 Q. That he had a history that predated the
22 event.

23 A. -- at that time or now that he was being
24 treated for herpes previous to?

1 those symptoms have been unabated despite the
2 attempts of treatment.

3 I think one could argue that his lack of
4 response to anti-inflammatory medications may mean
5 that this is not an overtly inflammatory disorder.
6 It doesn't mean that it's still not a real direct
7 and causal relationship to the vaccine though.

8 Q. Put aside the cause, which is of little or
9 no importance to me, I'm trying to figure out what's
10 wrong with Mr. Jeffries, as you have been for a
11 number of years. I understood you to tell me that
12 you believe that you know what's wrong with him, and
13 that's what I want you to describe to me, what body
14 system is being affected and why?

15 A. I believe it stems primarily from a
16 central nervous system problem. Although, the
17 nervous system also involves the gut and so it's
18 quite conceivable to me that his abdominal symptoms
19 relate to nervous system involvement of the
20 innervation of his visceral organs in the abdomen.

21 I believe that his persisting muscle
22 pains, his persisting cognitive problems, his—
23 persisting weakness, predominantly favoring his
24 right side relate to some sort of an immune-mediated

1 make a diagnosis, to give a definitive diagnosis, or
2 to exclude one.

3 Q. Okay. In this case we know we have the
4 patient's history as one of the tools that would go
5 into your reasoning to what is wrong with this
6 particular patient, that's the given, right?

7 A. That's very important.

8 Q. All right. Your clinical exams, as I read
9 them, and I could be wrong on this because I only
10 got them last night in their entirety, but the
11 clinical exams by and large were negative in their
12 findings, correct?

13 A. More recently, going from my memory, I
14 would say within the last year or 18 months Eric has
15 exhibited some mild right-sided weakness, decreased
16 arm swing with his gait on the right side, and so
17 that is, I think, a significant finding. It's not a
18 normal finding. Other --

19 Q. How did you measure -- I'm sorry.

20 A. Other than that, the remainder of his
21 physical exam findings have been very unremarkable.

22 Q. How did you measure the decreased strength
23 on the right side?

24 A. By resistance muscle testing, asking him

1 A. He certainly has.

2 Q. And desired to explore them to the nth
3 degree?

4 A. He has been very active in his own care
5 and his own case management, yes.

6 Q. In fact, he's been the most active patient
7 you've ever had?

8 A. That would be a fair statement.

9 Q. When he comes in with his history, I'm
10 assuming that you take the history at face value?

11 A. Don't know what history you would be
12 specifically referring to.

13 Q. Whatever history he --

14 A. Anything that he comes in and might
15 mention to me, I always -- I always listen.

16 Q. All right. Let me make it more concrete.
17 If he comes in and tells you I took the boys to
18 Florida last week and it wiped me out for four days,
19 that would be the kind of history you would take,
20 accept at face value, and go on, right?

21 A. Yes.

22 Q. That he's having difficulty cognitively,
23 something you take at face value and go on?

24 A. For the most part, yes.

1 A. It was one of the ones that were
2 considered, but were determined that he did not have
3 fibromyalgia, yes.

4 Q. So now we're talking about as of yet an
5 unidentified disease process, at least as far as
6 medical literature is concerned, that is affecting
7 Mr. Jeffries?

8 A. Well, other than the case reports in the
9 literature, which you have seen the reports from
10 some of the other specialists who have made note of
11 a series of patients that they have seen with
12 similar illnesses. It does not yet carry a specific
13 diagnostic label in the medical literature.

14 Q. When you say other experts in the field,
15 are we talking about Dr. Hyde in large part?

16 A. Well, mostly talking about Dr. Weisbraun,
17 I believe --

18 Q. Dr. Weisman?

19 A. -- who saw the patient.

20 Q. Let me ask you a question about those two
21 while we have them on the table. Do you know either
22 Dr. Hyde or Dr. Weisman?

23 A. I do not.

24 Q. Do you know whether or not they earn their

1 his symptoms, that's a rare process, but I'm not
2 sure that it's atypical for that process.

3 Q. How many patients like Mr. Jeffries do you
4 have, Doctor?

5 A. I don't have any others, thank the Lord
6 for that.

7 Q. How many patients do you have that have
8 gone to the extent of using their own funds to fly
9 to England, Brussels, Ottawa, Milwaukee, California,
10 Oklahoma, Alabama, Massachusetts, Florida, all for
11 purposes of seeking a diagnosis?

12 A. None. And also say that none of the other
13 patients that I have who I do treat for obsessive
14 compulsive disorder, and who I see with somatization
15 disorder are ever that persistent or that willing to
16 go to that extent, or to risk potential loss of his
17 diagnosis that we have taken so much pains to go to
18 to try to narrow the scope of, by going back out on
19 another limb to chase down another possibility.

20 Only ones who really are interested I
21 would suggest -- I would say that that strikes me as
22 someone who really wants to be well, not someone who
23 wants to continue to focus on his symptoms, which
24 people with somatization disorder prefer to do.

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19 Ohio, on Tuesday, October 28, 2003, at 4:20 PM.

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1 or the other on the evaluation of Mr. Jeffries?

2 MR. ROBERTS: Objection.

3 A. To my knowledge, again I'm not an expert
4 in this area, but the finding of IgA nephropathy in
5 a first degree relative would not impact Mr.
6 Jeffries -- the evaluation of Mr. Jeffries' medical
7 condition. It would not lead me in a direction to
8 look for other possibilities in him.

9 Q. September 10th, 2002 you've got a report
10 from the University of Chicago, Department of
11 Neurology from a Dr. Roos?

12 A. Yes.

13 Q. Dr. Roos's examination was completely
14 negative; is that correct?

15 MR. ROBERTS: Objection.

16 A. Other than decreased arm swing on one
17 side, he doesn't note which side.

18 Q. In the assessment -- now that I've dropped
19 it I may never find it again.

20 A. I can give you my copy.

21 Q. I've got it. In the assessment the doctor
22 found that the episodes of paresthesia, weakness,
23 pain, mental cloudiness are in contrast to the
24 patient's neurologic -- normal neurologic exam?